ALPINE THERAPEUTIC MASSAGE
Phoenix Michelle Alexander, L.M.P.#4392
253-838-3336

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CONFIDENTIAL CLIENT INFORMATION FORM

Please Print:

Name____________________Phone________________Birthdate__________
Address__________________City____________Zip______Phone__________
Employer______________Employer's Address__________________Phone__________
Occupation______________Chiropractor __________________Phone __________
Physician________________Phone____________
Emergency Contact______________Phone______________Relationship __________
e-mail address :________________________(E-mail will keep you informed of special promotions.)

Health History:

Are you currently taking any medication?_____If so, what?_________For what condition?____________
Are you Pregnant?_____How many weeks?______Have you ever had surgery?______When____________
For what condition?________________Date of last Physical Exam__________________
Have you had a recent Injury or Illness?_____What?____________When?_____Hospitalized?______
What results do you want from your massage?__________________________________
Areas needing special attention in your massage________________________________

Please check the box in front of any conditions that apply to you:

( ) High Blood Pressure	( ) Phlebitis	( ) Varicose Veins	( ) Blood Clots
( ) Low Blood Pressure	( ) Diabetes	( ) Heart Trouble	( ) Seizures/Epilepsy
( ) Contagious Condition	( ) Cancer	( ) Tumors	( ) Arthritis
( ) Ulcerated Colon	( ) Neck/Spinal Injury	( ) Scoliosis	( ) Back Pain
( ) Headaches	( ) Disc Problems	( ) Stroke	( ) Allergies
( ) Skin Disorders	( ) Athlete's Foot	( ) Aids/HIV	( ) Contacts
( ) Dentures	( ) Muscle Tightness	( ) Sprain/Strain	( ) Numbness
( ) Stress	( ) Fever	( ) Cold/Flu	( ) Sinus Congestion

( ) Other ____

I understand that massage is given for the purpose of stress reduction, relief from muscular tension, spasm, pain, or for increasing circulation. I understand that **Massage Practitioners do not diagnose** illness, disease, or any other physical or mental disorder. They don’t prescribe medical treatment, pharmaceuticals, nor perform spinal manipulation. It has been made clear to me that **Massage is not a substitute for medical examination** or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all my known medical conditions and will keep my Massage Practitioner updated on my health.
I give my consent to receive massage therapy *Initials*__________

Financial Policy:

Payment: Is due at the time of each visit, unless other specific arrangements are made. I acknowledge that my health insurance policy is an arrangement between the health plan and myself. I understand that I am responsible for all bills incurred during treatment. I understand that ALL insurance payments are due within 60 days of treatment.

Cancellation Policy: Please give 24 hours notice if you are unable to keep your appointment. Appointments cancelled less than 24 hours in advance will be charged $30.00 for late cancellation. (Emergencies will be handled on a case-by-case basis.)

Reservation with a credit card may be required if you schedule with less than 24 hours notice.

No Show Policy: If you do not call and cancel your appointment, 24 hours prior to you appointment time, you may be charged the full amount of time reserved for you. (Emergencies will be handled on a case by case basis.)

Insurance clients will be billed personally for missed appointments.

I have read and understand the financial and cancellation policy. *Initials*__________

Privacy Policy:

I have been given a copy of the Privacy Policy. I don’t have any questions about it. ***Initials*** __________

(Or I have questions and would like the Privacy Officer to contact me.) *Initials*__________

Signature __________________________________ *Date*__________

I Reserve The Right To Refuse Anyone Service